STATE OF NEW HAMPSHIRE
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BUREAU OF EMERGENCY MEDICAL SERVICES

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TRAUMA MEDICAL REVIEW COMMITTEE

COMMITTEE MEETING

October 24, 2007
Richard M. Flynn Fire Academy
Concord, New Hampshire

Members Present: John Sutton, MD, Kathy Bizarro, James Paquette, EMTP, Patricia Sampson, RN, Rajan Gupta, MD

Guests: Sue Barnard, RN, Janet Houston, Mary Grohosky, RN, Fred VonRecklinghausen, EMTP, Tim McGough, EMTP, Joni Iarrabino, RN, Doreen Gilligan, RN, Sarah Greer, MD, Greg Baxter, MD, John Leary, RN, EMTP

Bureau Staff: Clay Odell, EMTP, RN

I. Call to Order

The meeting of the Trauma Medical Review Committee was called to order by Chair John Sutton at 9:30 am on Wednesday October 24, 2007 at the Richard M. Flynn Fire Academy in Concord, NH.

Item 1. **Introductions:** Attendees went around the table and introduced themselves.

Item 2. **Minutes**. The minutes from the September 19th, 2007 meeting were approved.

IV. Committee Discussion Items

Item 1. **Renewal and Hospital Updates** Clay reported that Androscoggin Valley Hospital's application for trauma hospital renewal was ready for consideration today.

Item 2. **Trauma Conference** Clay reported that things are moving along well for the trauma conference. A pdf file of the brochure will be sent out this week, and the printed brochures will be sent out next week.

Item 3. **NH Bureau of EMS Report** Deferred discussion due to time considerations. Copies of the Bureau report were available for attendees.

III. Old Business

Item 1. Revision of NH Trauma Plan Dr. Sutton opened the discussion by saying that the consensus of last month's meeting was that the criteria for Level II trauma hospitals in NH has diverged substantially from guidelines established by the American College of Surgeons. For example, the waiver of neurosurgeon coverage has not proven successful, and hospitals admit to not being able to provide consistent coverage for other surgical specialties such as thoracic surgery. This trend will not likely improve, but will instead be likely to result in NH criteria becoming more disconnected from national guidelines.

The discussion centered around developing NH criteria for Level II trauma hospitals that are much more in line with national guidelines, with the primary concept being consistency. It is inappropriate that at Level II trauma hospitals' levels of trauma care vary widely from day to day, and even at different times of the day, and that individual surgical subspecialists are inconsistent in the care they are comfortable in providing.

It was suggested that Level II criteria in NH should set the bar higher than it currently is, knowing that none of the four current Level II trauma hospitals would be able to achieve that Level without a significant commitment of resources. The consensus of the group was that the four Level II's would find that plan acceptable since they would all be in the same boat. Achieving a true Level II in the Southern tier would remain as a goal of the NH Trauma System.

This left discussion about what a Level III trauma hospital would look like. Clay said he felt strongly that national criteria for a Level III hospital were not high enough for the needs of the urban and suburban parts of the state. Particularly the fact that the ACS did not require Level III hospitals to have any neurosurgical coverage was troubling. A significant percentage of trauma has a neuro component. The NH Trauma System must make provisions for neurotrauma care in cities such as Concord, Manchester, Nashua, and the Seacoast. Relying on Level I trauma hospitals a significant distance from these cities was not a good idea.

Perhaps the NH Trauma Plan for a Level III should require a higher standard than the ACS Level III. It was pointed out that the Pennsylvania Trauma System set criteria higher than the ACS, so there is a precedent.

Dr. Baxter commented, why aren't we demanding that we have a solid Level II trauma hospital in Southern NH? We should get the public, the legislators, the Governor and others to recognize the need for such a facility, and to exert pressure and/or provide incentives for at least one of the hospitals to pursue ACS verification of Level II trauma capability.

It was pointed out that changes that will be made in the standard would not apply immediately. Hospitals would retain their current level of assignment until it expired. Upon expiration the hospital would pursue whatever level they were capable of at that time.

In response to a suggestion that NH get out of the business of assigning trauma hospitals and defer it to the American College of Surgeons, Kathy Bizarro cautioned that we need to retain the inclusive nature of the voluntary NH Trauma System. If we set the bar too high, and required hospitals to pay for an ACS site visit, a number of hospitals that currently actively participate in the system might opt out.

Dr. Sutton said that the philosophy of the NH Trauma System must stay inclusive and voluntary, but that having standards for official recognition of trauma capabilities are necessary. The NH Trauma System recognizes that due to geographic and other factors, all NH acute care hospitals will take care of trauma patients. We would like all NH hospitals to actively participate in the program and receive recognition for that fact. But the fact is that not all hospitals actively participate now, and some of those that don't still refer to themselves as "trauma centers". It was the consensus of the group that this was misleading and should be corrected in the revised plan as well as in legislation or rule.

Kathy Bizarro made a motion to accept four levels in the revision of the NH Trauma Plan to reflect a true ACS Level I and II, a Level III that reflects the clinical capabilities and standards of the current Level II criteria, and Level IV. Motion seconded by Jim Paquette. Motion accepted unanimously.

Another concept that was discussed was statewide trauma registry. Dr. Sutton discussed the process that Maine uses for trauma data. Maine requires submission of trauma registry data, but instead of maintaining a state trauma registry, has hospitals submit their data to the National Trauma Database (NTDB), then accesses that database for statewide reports. There are 55 data elements in the NTDB.

A related data project would be collecting data about patients that were transferred. This database could help answer a number of questions about the trauma system and enable benchmarking of hospitals for trauma care. This plan could be built into the new trauma plan and could be an ad hoc project with questions that vary periodically.

Dr. Sutton said we should consider adding to the plan that all hospitals that actively participate in the NH Trauma System should be required to send a representative to the TMRC meetings.

Dr. Sutton asked people to consider other things to bring to the trauma plan such as educational requirements.

Clay was charged with revising the "strawman" document that had been distributed several months ago to reflect the current discussions, such as the different levels and submitting trauma registry data to the NTDB.

Clay asked that members and guests think about how to deal with the neurosurgeon coverage issue in the urban areas. This is a major issue that is complex and has no simple solution. Dr. Sutton is opposed to the "footnote solution".

There was a discussion about regionalization of neurosurgical resources in the southern tier. The challenge is to get neurosurgeons involved in the discussion. Dr. Gupta suggested looking into whether the American Association of Neurological Surgeons had a chapter in NH. Clay will look into that and continue to try to get a neurosurgeon to provide input.

Sue Barnard said we should explore role of physician assistants or nurse practitioners in the plan. Midlevel practitioners are utilized more and more, with backup by physicians, and may have a role in the trauma resuscitation. ACS does not appear to recognize the utility of PA's and NP's, but they may be included in the NH plan.

Janet Houston said the plan should specifically refer to written transfer guidelines and pediatric considerations. Janet discussed the EMS-C committee's work in coming up with criteria for credentialing hospital emergency departments ability to treat critically ill or injured children. Janet will send out drafts of this effort for consideration for inclusion in the trauma plan as we go along.

Clay recommended that we consider removing references to equipment requirements as ACS had removed them some time ago. The consensus was that this was acceptable.

IV. New Business

Item 1. Androscoggin Valley Hospital Trauma Assignment Renewal Application

The TMRC reviewed the renewal application for Weeks Medical Center. They are currently a Level III trauma hospital and are seeking renewal at that level. Doctor Jeff Johnson, Medical Director of Weeks' Emergency Department was in attendance at today's meeting to respond to questions.

Weeks' application had been considered previously at the December 2005 TMRC meeting, and action was tabled pending the opportunity to ask representatives of Week's Medical Center for clarification regarding trauma PI and trauma team response. Dr. Johnson talked about the trauma PI initiatives at his hospital, explained the current status of trauma team activations, and expressed a willingness to work with Clay to develop plans for an improved response to trauma resuscitations.

Following the discussion a motion was made by Steve Bateman to approve Weeks' application, seconded by Sharon Phillips. The members of the TMRC voted unanimously to approve the application. The letter of approval to Weeks Medical Center will reflect the above discussion.

V. Public Comment

Clay announced that the Trauma Coordinator's Working Group would be meeting immediately following adjournment of the TMRC meeting.

VI. Adjournment

Dr. Sutton adjourned the meeting at 11:30. He advised the group that the next scheduled meeting of the Trauma Medical Review Committee would be December 19, 2007 at 9:30 a.m. at the Richard M. Flynn Fire Academy.

Respectfully submitted:

Clay Odell, EMTP, RN
Trauma Coordinator